GENERAL INFORMATION – Form 701

The Form BWC-701 (hereafter referred to as Form 701) is used to report to the Bureau payment of weekly compensation benefits made to the employee. Attorney fees, rehabilitation costs, medical expenses, etc. should not be reported on the form. Burial expenses must be reported by the employer on Form BWC-106 or a receipt of payment will be requested.

The filing number should always be #1 the first time the Form 701 is submitted for a claim, and then increase sequentially for subsequent filings.

It is critical that all subsequent filings contain the **exact** SSN and DOI that was reported on the first filing. If this information was previously reported in error, the correction(s) should be clearly marked on the form.

Friend of the Court payments should not be reported to the Bureau.

All Bureau orders have a nine digit number written in the upper right hand corner consisting of the mailed date and a three digit sequential number. All Form 701's that are filed pursuant to an award (basis of payment anything other than "A") should have the order number included in the space provided below section D.

Redemptions and advance payments do not need to be reported on a Form 701. If the redemption involves a claim which is in payment status, the system will automatically close out the weekly payments **assuming** that the weekly rate, date of injury and carrier listed on the redemption order match the information on the latest Form 701. If not, a Form 701 must be filed closing out the weekly payments. A Form 701 must also be filed if partial benefits are being paid at the time of the redemption or an advance payment results in a reduction or termination of the weekly rate.

In February of each year, the Bureau runs a program which closes all open paying claims as of December 31 and reopens them on January 1 of the next year. Once that is done, an Open Claim Validation Report is sent to each carrier listing all claims that closed and reopened as well as those that could not be closed because of an error. This report should be used to verify that all claims on the report are still in open payment status and that the rate is correct. If not, the appropriate Form 701's should be filed. If partial benefits are being paid, the employee worked less than a 5 day work week, or the compensation rate is in error, a Form 701 **must** be filed.

Form 701's which are filed to report payment of accrued benefits as a result of an order or agreement which cover multiple benefit periods should have the Report of Accrued Benefits worksheet (or a similar format) attached and include all available information: basis, benefit type, special payment, weekly rate, from and through dates and total amounts paid for each payment period. Interest payments, when applicable, should be reported on a separate line from the accrued benefit period(s) and include the special payment code, through date and total interest payment only.

FILING INSTRUCTIONS FOR FORM 701

PART A

This section must be completed in its entirety the first time the Form 701 is filed on a claim. On all subsequent filings, only items 1-3 and 17-21 are necessary. All other items do not need to be completed unless they have changed from the previous filing. Extreme care should be taken to ensure that all filings contain the same SSN and DOI that were first reported to the Bureau.

#1. Social Security Number: 9 digit numeric.

#2. Date of Injury: Must be complete date (MM/DD/YYYY).

#3. Employee Name: Employee's last name, first name and middle initial.

#4. Date of Birth: Must be complete date (MM/DD/YYYY)

#5. Date of Death: If employee is deceased, enter complete date (MM/DD/YYYY). A Form 106 must also be filed.

#6-9. Employee's Address: Complete address of employee, including number, street, city, state and zip code.

#10. Employer Name: Enter complete business name of employer (DBA, etc.)

#11. Federal ID Number: Enter 9 digit Federal ID number used by the employer listed in #10.

#12. Injury Location Code: This item only needs to be completed if the employer has multiple locations. A three digit code was assigned by the bureau for each different location, and carriers were notified of the codes in 1991. Enter the location code corresponding to the address where the claimant was employed at the time of injury.

#13-16. Employer Address: Complete address of employer, including number, street, city, state and zip code.

#17. Carrier or Self-Insured Name: Enter complete name of insurance company or self-insured employer. A service agent name should not be reported in this field.

#18. NAIC or Self-Insured Number: 5 digit NAIC number and 3 digit group code should be reported for insurance companies and 8 digit self-insured ID number should be reported for self-insureds.

#19. Service Agent Name: Enter name of service agent handling claim, if applicable.

#20. Service Agent ID Number: The 3 digit service agent ID number assigned by the bureau must be reported if a service agent name is present in #19.

#21. Zip Code of Issuing Office: Zip code of insurance carrier, self-insured employer or service company filing the form. The zip code will be used in conjunction with the carrier or service agent ID to identify the mailing address of the appropriate office where correspondence should be sent.

#22. Carrier or Self-Insured Claim Number: Submitter's claim or file number, if applicable. This number will appear on all system generated correspondence.

#23. Date Carrier Received Notice of Injury: The date carrier received notice of injury. This information is required on the first filing of all voluntary payment cases to determine promptness of payment. If it is not present on the form, a system generated letter will be sent to the submitter.

#24. Date First Payment Made: The date the first check was sent out on this claim. This date is required on the first filing of all voluntary payment cases to determine promptness of payment. If it is not present on the form, a system generated letter will be sent to the submitter. If the employer is continuing to pay wages while the compensability issue is being resolved or benefits are being coordinated under a wage continuation plan, the date first payment made should be the same as the from date in Part D.

PART B

The section must be completed in its entirety the first time the form is filed on a claim. On all subsequent filings, the items only need to be completed if they have changed.

#25. Nature of Injury: Provide a brief description of the injury or disease. If desired, the codes from Table 212 (see attached) may be entered in addition to the description.

#26. Part of Body: Provide a brief description of the part of body affected by the injury or disease. If desired, the codes from Table 211 (see attached) may be entered in addition to the description.

#27. Average Weekly Wage: Include total weekly wages from place of injury, excluding fringes. This information is required.

#28. Discontinued Fringes: Weekly fringe benefits from place of injury which are not continuing during the disability period. This information is required if the weekly compensation base rate is less than 2/3 of the state average weekly wage for the year of injury. If this situation occurs and there are no discontinued fringes, enter zero.

#29. Second Employer AWW: Include total wages from second employer, if applicable.

#30. Second Employer Discontinued Fringes: Include discontinued fringes from second employer, if applicable.

#31. Tax Filing Status on Date of Injury: Employee's tax filing status at the time of injury using the Federal income tax eligibility criteria. The status does not change during the life of the claim. This information is required.

#32. Last Day Worked: Last day preceding the current disability period in which the employee received full wages. This information is required.

#33. Number of Days in Work Week: Number of days the employee is regularly scheduled to work per week. This information is required. If the employee works less than a 5 day week, we are unable to calculate the total amount paid. Therefore, if any of these claims are in open payment status at the end of the year, a Form 701 must be filed reporting the amount of compensation paid during the year. ***All payments made for dates of injury on and after May 11, 1999 must be calculated on a 7-day work week per Rule 408.31a.***

#34. Number of Dependents: Number of dependents, not including the employee. This information is required.

PART C

This section must be completed in its entirety each time the form is filed unless the reason for filing is "C" (terminating benefits). In that instance, only item 35 (reason for filing) is necessary. The information should always pertain to the latest payment period reported on the form, i.e., when filing is to report a rate change, the information in part C should correspond to the new rate.

#35. Reason for Filing: The appropriate code must be entered on all filings:

A = *Used whenever benefits are commencing and continuing.*
B = *Used whenever there is a change in the current rate and benefits are continuing.*
C = *Used whenever benefits that were previously reported are now being terminated.*
D = *Used whenever benefits that have never been previously reported are both commencing and terminating.*
E = *Used whenever the rate is staying the same but reimbursements are now being received from either the Silicosis, Dust Disease and Logging Industry Compensation Fund; the Self-Insurers' Security Fund; or the Vocationally Handicapped Provisions of the Second Injury Fund.*
F = *Used whenever a claim that had previously been in payment status is now reopening and benefits are continuing.*
G = *Used whenever benefits are both commencing and terminating on a claim that had previously been in payment status.*
H = *Used to report the amount of partial benefits that were paid on all claims which are in partial benefit status as of 12/31. A wage statement should also be attached. This code should also be used when reporting yearly payments on any claim still in payment status at the end of the year in which the employee worked less than a 5 day work week.*
I = *Used whenever information was improperly reported on a previous Form 701.*

#36. Weekly Compensation Base Rate: The base rate which is owed prior to taking into account any adjustment(s) specified in item 37.

#37. Weekly Adjustments to Base Rate: This item should always be completed when the base rate in item 36 does not match the "total weekly rate" in Part D. Record the appropriate code(s) and **weekly** dollar amount(s).

If the code is equal to A-G (coordination of benefits), the appropriate section in Part E should also be completed on the back of the form. If the code is equal to "J" or "K", the order number must also be entered in the space provided below Part D.

#38. Weekly Amount Being Reimbursed by a Fund: Indicate the appropriate code(s) and **weekly** dollar amount(s) being reimbursed by the Silicosis, Dust Disease and Logging Industry Compensation Fund; the Self-Insurers' Security Fund; or the Vocationally Handicapped Provisions of the Second Injury Fund. Do not record any Compensation Supplement Fund payments (adjustment code of "I") or Second Injury differential benefits (adjustment code of "L"). These amounts should be reported in #37. Also, do not report any reimbursements received as a result of the 70% or Dual Employment provisions. This information will be provided to us by the Second Injury Fund.

PART D

This section should be completed as follows:

FILING REASON of "A" or "F"

Complete the basis of payment, benefit type, special payment (if applicable), weekly rate and from date.

FILING REASON of "B"

Complete the entire first line (except for termination reason) in order to close out the old rate, as well as the first half of the second line in order to report the new rate and from date. If benefits covered more than one calendar year, the from date on the first line should always be January 1 of the current year.

FILING REASON of "C"

Complete the entire first line showing the total payments made for the current calendar year only.

FILING REASON of "D" or "G"

Complete the entire first line showing the total payments that were made.

FILING REASON of "E"

Complete the entire first line in order to close out the rate and payment period (if payments covered multiple calendar years, use January 1 of the current calendar year) for which the carrier is responsible, as well as the first half of the second line in order to give us the new from date for which reimbursement takes effect.

FILING REASON of "H"

Complete the entire first line (except for termination reason) in order to report the partial payments that were made during the previous calendar year (show the through date as close to 12/31 as possible) as well as the first half of the second line using a from date one day after the through date. A partial payment worksheet must also be attached to the form.

BASIS OF PAYMENT

Indicate the appropriate code from the back of the form. When a claim is being paid pursuant to any type of order, including a Voluntary Payment Form (MDL-1-115), include the order number in the space provided below Part D.

BENEFIT TYPE

Include the appropriate code from the back of the form. This information is always necessary unless a Special Payment type code is present. Please note that the old benefit type of Temporary Total has been replaced by General Disability. Also, the first filing reporting a specific loss benefit type ("C") should include a copy of the amputation chart signed by the physician or affidavit of vision loss, whichever applies. The number of loss weeks and effective date of loss should be completed below Part D.

When benefits are changing from partial to total, or partial benefits are being terminated, a wage statement showing the calculation of partial payments must also be attached to the Form 701.

When the benefit type is "D" (Permanent Total), there must be an adjustment code of "L" (SIF differential benefits) and an amount reported in #37.

SPECIAL PAYMENT

This code is only necessary when the payment period is pursuant to an award. When interest is being reported, the through date should reflect the date that the accrued benefits were paid.

TOTAL WEEKLY RATE

This should reflect the amount the employee actually receives per week and should equal the Base Rate in line 36 plus or minus any adjustments reported in line 37.

The weekly rate can be left blank when the benefit type is "B" (partial wage loss).

FROM DATE

The effective date of the rate/benefit type for the payment period. Do not include the waiting week for the initial disability period unless benefits were paid for those dates. When terminating benefits that were paid during more than one calendar year, the from date should always reflect the current year only. This field may be left blank when special payment code is "B" (interest).

THROUGH DATE

The ending date (current calendar year only) of the rate/benefit type or the payment termination date, whichever applies. If a special payment code of "B" (interest) is being reported, the through date should reflect the date accrued benefits were paid.

TOTAL AMOUNT PAID

Indicate the total amount paid to the employee for the payment period. This field is required whenever a through date is present. If an overpayment was made but not recouped, the amount actually paid to the employee should be reflected. If partial benefits are being terminated, the total amount paid must be entered in Part D. It is not sufficient to simply attach a partial payment worksheet.

TERMINATION REASON

When the reason for filing is "C", "D" or "G" (all terminating benefits), the termination reason code is required. When the termination reason is "B" (recovered from disability), a medical report must be attached. Whenever partial benefits are being terminated, a partial payment worksheet must be attached to the form. If the termination reason is "E" (claimant deceased), a death certificate must be attached.

ORDER #

This number is required on all Form 701's that are filed pursuant to an award, including voluntary payment agreements (Form 115's). Enter the 9 digit order number which is located in the upper right hand corner of all orders mailed out by the Bureau.

SPECIFIC LOSS

If the benefit type code is "C" (specific loss), this information is required on the first filing. Enter the exact number of specific loss weeks as well as the effective date of the loss. An amputation chart (MDL-728) or vision affidavit, whichever is applicable, should also be attached.

"OTHER" FILING CODES

If any of the codes used on the form refer to "other", the exact reason must be listed here.

#39. Authorized Signature: The signature of an individual authorized to file this form.

#40. Person Handling Claim: Print the name of the individual who is handling the claim. This is the person we will contact with any questions.

#41. Telephone Number: Enter the telephone number, including extension, of the individual listed in #40 who is handling the claim.

#42. Date: Enter the date the form was prepared.

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# _____

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
6. Employee Street Address		7. City	8. State	9. ZIP Code
10. Employer Name			11. Federal I.D. Number	12. Injury Location Code
13. Employer Street Address		14. City	15. State	16. ZIP Code
17. Carrier or Self-Insured Name			18. NAIC or Self-Insured Number	
19. Service Company/TPA Name (If applicable)			20. Service Company/TPA I.D. Number	
21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury		24. Date First Payment Made

Part B

25. Nature of Injury		26. Part of Body	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason

If basis of payment is other than “A” (Voluntary Payment) or line 37 is equal to “J” or “K”, enter Order # _____

If benefit type is “C” (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent “Other”, please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers’ Disability Compensation Act, 408.31(6a-d) Completion: Mandatory Penalty: Workers’ Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Filing Codes for Form BWC-701

31. Tax Filing Status
A = Single
B = Single/Head of Household
C = Married/Filing Joint
D = Married/Filing Separate

35. Reason for Filing
A = Commencing Benefits
B = Change in Weekly Rate
C = Terminating Benefits
D = Commencing and Terminating Benefits
E = Reimbursement by a Fund
F = Reopening Claim
G = Reopening and Closing Claim
H = Yearly Report of Partial Payments
I = Error on Previous filing (attach copy)

37. Weekly Adjustments to Base Rate
A = Wage Continuation Offset (-)
B = Social Security Coordination (-)
C = Pension Offset (-)
D = Unemployment Offset (-)
E = Disability Insurance Offset (-)
F = Self Insurance Offset (-)
G = Other Benefit Coordination (-)
H = Age 65 Reduction (-)
I = Compensation Supplement (+)
J = Advance Payment (-)
K = 30% Appeal Adjustment (-)
L = SIF Differential Benefits (+)
M = Double Compensation (+)
N = Third Party Offset (-)
O = 2 Years Continuous Disability (+)
P = Recoupment of Overpayment (-)
Q = Other

38. Reimbursement by a Fund *
A = Silicosis, Dust Disease and Logging Industry Compensation Fund
B = Self-Insurers' Security Fund
C = Vocationally Handicapped Provisions/SIF
D = Other

* DO NOT report reimbursements received as a result of the 70% or Dual Employment provisions. This information will be provided to us by the Second Injury Fund.

Part D - Basis of Payment
A = Voluntary Payment
B = Open Award
C = Closed Award
D = Stipulated Award
E = Compromise
F = Form 115 Voluntary Pay

Part D - Benefit Type
A = General Disability
B = Partial Wage Loss
C = Specific Loss
D = Permanent Total
E = Death
F = Other

Part D - Special Payment
A = Accrued Benefits
B = Interest
C = 30% Appeal Adjustment
D = Other

Part D - Termination Reason
A = Returned to Work with No Wage Loss
B = Recovered from Disability (Attach Medical)
C = Award Reversed
D = End of Specific Loss
E = Claimant Deceased (Attach Death Certificate)
F = Closing Out Weekly Due to Redemption
G = Closing Out Weekly Due to Advance Payment
H = Other

PART E. — Coordination of Benefits

Section 1-5

	1. Pension	2. Wage Continuation	3. Disability Insurance	4. Self Insurance	5. Other
A. Weekly Benefit Amount					
B. 80% After-tax Amount of (A)					
	X 1.25	X 1.25	X 1.25	X 1.25	X 1.25
C. 100% After-tax Amount					
D. FICA Tax*					
E. State Income Tax*					
F. % Employer Contribution					
G. Income to Be Coordinated**					

* Does not apply in all cases. If applicable, include the value of FICA and state income tax using the rates provided in the back of the bureau's rate tables corresponding to the year of injury.
** Line G = (Line C + D + E) X Line F (This figure should appear in Section 37 with the appropriate adjustment code)

Section 6 - Social Security

A. Monthly Old-Age Benefit . . . . . $ _____
B. Weekly Old-Age Benefits (Above Amount ÷ 4.33) . . . . . $ _____
C. Total Amount of Social Security Benefits to be Coordinated (50% of Line B) . . $ _____ (Enter with Code "B" in Section 37)

Section 7 - Unemployment Compensation

A. Number of Weeks Awarded . . . . . $ _____
B. Beginning Date of Unemployment Compensation . . . . . $ _____ Scheduled Expiration Date _____
C. Total Weekly Unemployment Compensation Benefits . . $ _____ (Enter with Code "D" in Section 37)

Please complete all date fields with the MM/DD/YYYY format.

Print Reset Form

REPORT OF ACCRUED BENEFITS

SS# ____________________ DOI ____________ Employee Name _________________________

Order # _________________ Basis Payment Code _________ Year Paid ___________

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
						Deps ____ Base Amt $ _______ Adjustment Code ___ $ _______ ___ $ _______
						Deps ____ Base Amt $ _______ Adjustment Code ___ $ _______ ___ $ _______
						Deps ____ Base Amt $ _______ Adjustment Code ___ $ _______ ___ $ _______
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						Deps ____ Base Amt $ _______ Adjustment Code ___ $ _______ ___ $ _______

Basis of Payment

A = Voluntary Payment
B = Open Award
C = Closed Award
D = Stipulated Award
E = Compromise
F = Form 115 Voluntary Pay

Benefit Type

A = General Disability
B = Partial Wage Loss
C = Specific Loss
D = Permanent Total
E = Death
F = Other

Special Payment

A = Accrued Benefits
B = Interest
C = 30% Appeal Adjustment
D = Other

Weekly Adjustments to Base Rate

A = Wage Continuation Offset
B = Social Security Coordination
C = Pension Offset
D = Unemployment Offset
E = Disability Insurance Offset
F = Self-Insurance Offset
G = Other Benefit Coordination
H = Age 65 Reduction
I = Compensation Supplement
J = Advance Payment
K = 30% Appeal Adjustment
L = SIF Differential Benefits
M = Double Compensation
N = Third-Party Offset
O = 2-Years Continuous Disability
P = Recoupment of Overpayment
Q = Other

Nature of Injury Codes – Alpha Order

When two codes are listed, this first represents nature of injury and the second is part of body

Code	Description
300	Abrasions
183	Abscess
281	Aluminosis - aluminum exposure
100	Amputation or enucleation (loss of an eye)
272	Anemia
282	Anthracosis - coal dust
152	Anthrax
540	Anxiety
283	Asbestosis - asbestos fibers
110	Asphyxia
572	Asthma
274	Asthma, toxic (systemic poisoning)
552	Benign and unspecified tumor
590	Bites, human and non-toxic animal
300	Blisters
272	Blood diseases (includes purpura)
183	Boils
572	Bronchitis
274	Bronchitis, toxic (systemic poisoning)
153	Brucellosis
160	Bruise
130	Burn (chemical)
120	Burn or scald (heat)
260	Bursitis
284	Byssinosis - cotton dust
551	Cancer
183	Carbuncles
562/320	Carpal tunnel
310	Cartilage, torn
183	Cellulitis
561	Central nervous system
561	Cerebral palsy
510	Cerebrovascular & other circulatory conditions
159	Chicken pox
276	Colitis
520	Complications peculiar to medical care (toxic or non-toxic)
140/110	Concussion (brain, cerebral)
154	Conjunctivitis (non-toxic)
530	Conjunctivitis, chemical
160	Contusion

Code	Description
160	Crush
170	Cut
950	Damage to prosthetic devices (includes eyeglasses, false teeth, etc.)
540	Depression
540	Derangement, internal
185	Dermatitis, allergenic or contact
180	Dermatitis, unspecified
190	Dislocation & dislocated disc
110	Drowning
151	Dysentery, amebiasis
500	Effects of changes in atmospheric pressure (equilibrium)
200/840	Electric shock, electrocution
274	Emphysema
240	Environmental heat (does not include sunburn)
260	Epicondylitis
995	Epilepsy
184	Erythema, toxic
530	Eye diseases
210	Fracture
220	Freezing (includes frostbite)
260	Ganglion cyst
276	Gastro-enteritis
276	Gastro-intestinal diseases
273	Hay fever, toxic (systemic poisoning)
230	Hearing loss or impairment
991	Heart attack
991	Heart conditions
240	Heatstroke
320	Hemorrhoids (circulatory system)
330	Hepatitis (serum & infective)
250/410	Hernia, rupture
190/240	Herniated disc
159	Herpes
991	Hypertension
150	Infective or parasitic disease, unspecified
572	Influenza
274	Influenza, toxic (systemic poisoning)
294	Ionizing radiation - Isotopes

Nature of Injury Codes – Alpha Order

When two codes are listed, this first represents nature of injury and the second is part of body

Code	Description
293	Ionizing radiation - X-Ray
530	Iritis
260	Joints, inflammation or irritation
170	Laceration
551	Leukemia
184	Lichen
530	Loss of vision
551	Malignant tumor
159	Measles
540	Mental disorders
292	Microwave, radiation effects
561	Migraine
995	Miscarriage
400	Multiple injuries
159	Mumps
260	Muscles, inflammation or irritation
562	Nerves and peripheral ganglia (includes Bell's Palsy)
560	Nervous system, conditions of, unspecified
540	Neurosis
900	No injury or illness
999	Nonclassifiable
990	Occupational disease (not elsewhere classified)
159	Other infective diseases
995	Other injury, not elsewhere classified
287	Other pneumoconiosis and related diseases
184	Other skin conditions
279	Other toxic effects on one system only
190	Pinched nerve (back only)
310	Pinched nerve (other than back)
280	Pneumoconiosis & related diseases, unspecified
289	Pneumoconiosis with tuberculosis
572	Pneumonia
274	Pneumonia, toxic (systemic poisoning)
274	Pneumonitis
280	Pneumothorax
270	Poisoning, systemic, unspecified
271	Poisoning, toxic material
183	Primary Infections of the skin
184	Pruritus
170	Puncture

Code	Description
290	Radiation effects, unspecified
570	Respiratory System, conditions of, unspecified
581	Rhinitis
273	Rhinitis, toxic (systemic poisoning)
310	Rotator cuff tear
300	Scratches
200/840	Shock, electric
285	Siderosis - metallic dust
286	Silicosis - silica dust
273	Sinusitis, toxic (systemic poisoning)
189	Skin conditions, unspecified
170	Sliver
273/850	Smoke inhalation
310	Sprains
310	Strains
110	Strangulation
540/840	Stress
510	Stroke
110	Suffocation
291	Sunburn, etc. (non-ionizing radiation)
240	Sunstroke
580	Symptoms & ill-defined conditions (e.g., fainting)
260	Tendinitis
260	Tendons, inflammation or irritation
260	Tenosynovitis, stenosing
156	Tetanus
275	Toxic hepatitis
157	Tuberculosis
550	Tumor, neoplasm, unspecified
571	Upper respiratory
510	Varicose veins
295	Welder's flash (eyes only)
310	Whiplash

Part of Body Codes

Code	Description
410	Abdomen (include internal organs)
520	Ankle
318	Arm, multiple
319	Arm, not elsewhere classified
310	Arm(s), above wrist, unspecified
801	Arteries
420	Back (include back muscles)
311	Biceps
820	Bladder
801	Blood
800	Body system, unspecified
830	Bones
110	Brain
430	Breastbone
440	Buttocks
200	Cervical
141	Cheek
430	Chest (internal organs)
141	Chin
801	Circulatory system
450	Clavicle
420	Coccyx
110	Concussion
450	Deltoid
810	Digestive system
120	Ear(s), unspecified
121	Ear(s), external
124	Ear(s), internal
313	Elbow
840	Epilepsy
820	Excretory system
130	Eye(s)
130	Eyelid
148	Face, multiple parts
140	Face, unspecified
149	Face, not elsewhere classified
511	Femur
515	Fibula
340	Finger(s)
350	Fingertip(s)

Code	Description
530	Foot (not ankle or toe)
315	Forearm
149	Forehead
330	Hand (not wrist or fingers)
397	Hand & Finger(s)
198	Head, multiple
100	Head, unspecified
801	Heart
410	Hernia, inguinal
440	Hips
311	Humerus
820	Intestines
141	Jaw
830	Joints
820	Kidneys
513	Knee
519	Leg, not elsewhere classified
518	Leg, multiple
510	Leg(s) (above ankle), unspecified
144	Lips
500	Lower extremities, unspecified
598	Lower extremities, multiple
515	Lower leg
420	Lumbar
850	Lungs
141	Mandible
330	Metacarpal
530	Metatarsal
144	Mouth (includes sense of taste, excludes teeth)
700	Multiple parts (use when more than one major body part has been affected)
830	Muscles
830	Musculo-skeletal system
146	Nasal passages
200	Neck
840	Nervous system
999	Nonclassifiable (insufficient information to identify affected part)
146	Nose (includes sense of smell)
313	Olecranon

Part of Body Codes

Code	Description
130	Optic nerves
880	Other body systems
513	Patella
430	Pectorals
440	Pelvic organs
440	Pelvis
315	Radius
850	Respiratory system
430	Ribs
420	Sacrum
150	Scalp
450	Scapula
450	Shoulder(s)
146	Sinus
160	Skull
420	Spinal cord
420	Spine
430	Sternum
147	Teeth
830	Tendons
511	Thigh
430	Thorax
144	Throat
515	Tibia
540	Toe(s)
550	Toetip(s)
144	Tongue
311	Triceps
400	Trunk, unspecified
498	Trunk, multiple
315	Ulna
300	Upper extremities, unspecified
311	Upper arm
398	Upper extremities, multiple
801	Veins
130	Vision
320	Wrist

List of Examples

Filing Reason “A”	Commencing benefits (no adjustments to base rate	Example 1
Filing Reason “A”	Commencing benefits (with adjustments to base rate)	Example 2
Filing Reason “B”	Change in weekly rate	Example 3
Filing Reason “C”	Terminating benefits	Example 4
Filing Reason “D”	Commencing & terminating benefits	Example 5
Filing Reason “E”	Reimbursement by a Fund	Example 6
Filing Reason “F”	Reopening claim	Example 7
Filing Reason “G”	Reopening & Closing claim	Example 8
Filing Reason “H”	Yearly report of partial payments	Example 9
Basis of Payment “B”	Open award	Example 10
Basis of Payment “E”	Compromise	Example 11
Benefit Type “D”	Permanent Total	Example 12

Example 1

Filing Reason "A"

Commencing benefits (no adjustments to base rate)

Back to List of Examples

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/1997	6	3

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$299.54

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$299.54	02/02/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	02/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 2

Back to List of Examples

Filing Reason "A" | **Commencing benefits (with adjustments to base rate)**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/1997	6	3

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$299.54

37. Weekly Adjustments to Base Rate

A	$374.43						

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A			02/02/1997				

If basis of payment is other than “A” (Voluntary Payment) or line 37 is equal to “J” or “K”, enter Order # _____

If benefit type is “C” (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent “Other”, please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers’ Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers’ Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	02/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

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Filing Codes for Form BWC-701

31. Tax Filing Status
A = Single
B = Single/Head of Household
C = Married/Filing Joint
D = Married/Filing Separate

36. Reason for Filing
A = Commencing Benefits
B = Change in Weekly Rate
C = Terminating Benefits
D = Commencing and Terminating Benefits
E = Reimbursement by a Fund
F = Reopening Claim
G = Reopening and Closing Claim
H = Yearly Report of Partial Payments
I = Error on Previous filing (attach copy)

37. Weekly Adjustments to Base Rate
A = Wage Continuation Offset (-)
B = Social Security Coordination (-)
C = Pension Offset (-)
D = Unemployment Offset (-)
E = Disability Insurance Offset (-)
F = Self Insurance Offset (-)
G = Other Benefit Coordination (-)
H = Age 65 Reduction (-)
I = Compensation Supplement (-)
J = Advance Payment (-)
K = 30% Appeal Adjustment (-)
L = SIF Differential Benefits (+)
M = Double Compensation (+)
N = Third Party Offset (-)
O = 2 Years Continuous Disability (+)
P = Recoupment of Overpayment (-)
Q = Other

38. Reimbursement by a Fund *
A = Silicosis, Dust Disease and Logging Industry Compensation Fund
B = Self-Insurers' Security Fund
C = Vocationally Handicapped Provisions/SIF
D = Other

* DO NOT report reimbursements received as a result of the 70% of Dual Employment provisions. This information will be provided to us by the Second Injury Fund.

Part D - Basis of Payment
A = Voluntary Payment
B = Open Award
C = Closed Award
D = Stipulated Award
E = Compromise
F = Form 115 Voluntary Pay

Part D - Benefit Type
A = General Disability
B = Partial Wage Loss
C = Specific Loss
D = Permanent Total
E = Death
F = Other

Part D - Special Payment
A = Accrued Benefits
B = Interest
C = 30% Appeal Adjustment
D = Other

Part D - Termination Reason
A = Returned to Work with No Wage Loss
B = Recovered from Disability (Attach Medical)
C = Award Reversed
D = End of Specific Loss
E = Claimant Deceased (Attach Death Certificate)
F = Closing Out Weekly Due to Redemption
G = Closing Out Weekly Due to Advance Payment
H = Other

PART E. — Coordination of Benefits

Section 1-5

	1. Pension	2. Wage Continuation	3. Disability Insurance	4. Self Insurance	5. Other
A. Weekly Benefit Amount		**$450.00**			
B. 80% After-tax Amount of (A)		**$299.54**			
	X 1.25	X 1.25	X 1.25	X 1.25	X 1.25
C. 100% After-tax Amount		**$374.43**			
D. FICA Tax*					
E. State Income Tax*					
F. % Employer Contribution		**100%**			
G. Income to Be Coordinated**		**$374.43**			

* Does not apply in all cases. If applicable, include the value of FICA and state income tax using the rates provided in the back of the bureau's rate tables corresponding to the year of injury.
** Line G = (Line C + D + E) X Line F (This figure should appear in Section 37 with the appropriate adjustment code)

Section 6 - Social Security

A. Monthly Old-Age Benefit . . . . . $ _____
B. Weekly Old-Age Benefits (Above Amount ÷ 4.33) . . . . . $ _____
C. Total Amount of Social Security Benefits to be Coordinated (50% of Line B) . . $ _____ (Enter with Code "B" in Section 37)

Section 7 - Unemployment Compensation

A. Number of Weeks Awarded . . . . . $ _____
B. Beginning Date of Unemployment Compensation . . . . . $ _____ Scheduled Expiration Date _____
C. Total Weekly Unemployment Compensation Benefits . . $ _____ (Enter with Code "D" in Section 37)

Example 3

Back to List of Examples

Filing Reason "B" | **Change in weekly rate**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/1997	6	3

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$299.54

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$299.54	02/02/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers' Disability Compensation Act, 408.31(6a-d) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	02/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 3

Back to List of Examples

Filing Reason "B" | **Change in weekly rate**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 2

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.		

6. Employee Street Address	7. City	8. State	9. ZIP Code

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code

13. Employer Street Address	14. City	15. State	16. ZIP Code

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912			

Part B

25. Nature of Injury	26. Part of Body

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
			2

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
B	$299.54

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$299.54	02/02/1997	03/12/1997	1,647.47	1997	
A	A		$294.52	03/13/1997				

If basis of payment is other than “A” (Voluntary Payment) or line 37 is equal to “J” or “K”, enter Order # _____

If benefit type is “C” (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent “Other”, please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers’ Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers’ Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	03/23/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 4

Back to List of Examples

Filing Reason "C" | **Terminating Benefits**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Sprain (310)	Ankle (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/1997	6	3

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$299.54

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$299.54	02/02/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	02/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 4

Back to List of Examples

Filing Reason "C" | **Terminating Benefits**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 2

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.		

6. Employee Street Address	7. City	8. State	9. ZIP Code

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code

13. Employer Street Address	14. City	15. State	16. ZIP Code

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912			

Part B

25. Nature of Injury		26. Part of Body	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
C	

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$299.54	02/02/1997	04/06/1997	$2,695.86	1997	A

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers' Disability Compensation Act, 408.31(6a-d) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	04/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 5

Back to List of Examples

Filing Reason "D" | **Commencing & Terminating Benefits**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Burn (310)	Arm (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
A	02/01/1997	5	0

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$274.40

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$274.00	02/02/1997	03/12/1997	$1,536.64	1997	A

If basis of payment is other than “A” (Voluntary Payment) or line 37 is equal to “J” or “K”, enter Order # _____

If benefit type is “C” (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent “Other”, please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers’ Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers’ Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	03/13/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 6

Back to List of Examples

Filing Reason "E" | **Reimbursement by a Fund**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	03/06/95	DOE, John R.	05/20/38	

6. Employee Street Address	7. City	8. State	9. ZIP Code
512 Baker Street	Detroit	MI	48226

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Fred's Foundry	38-2222222	001

13. Employer Street Address	14. City	15. State	16. ZIP Code
4480 W. Fort Street	Detroit	MI	48288

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48288	WC654321	03/10/1995	03/21/1995

Part B

25. Nature of Injury	26. Part of Body
Silicosis (286)	Lungs (850)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$610.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	03/06/1995	5	2

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$383.02

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$383.02	03/07/1995				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	03/21/1995

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 6

Back to List of Examples

Filing Reason "E" | **Reimbursement by a Fund**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 2

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	03/06/1995	DOE, John R.		

6. Employee Street Address	7. City	8. State	9. ZIP Code

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code

13. Employer Street Address	14. City	15. State	16. ZIP Code

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48288	WC654321	03/10/1995	03/21/1995

Part B

25. Nature of Injury	26. Part of Body

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$383.02

37. Weekly Adjustments to Base Rate

	$		$		$		$
	$		$		$		$

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

A	$ 383.02		$		$		$

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$383.02	01/01/1997	03/03/1997	$3,370.58	1997	
A	A		$383.02	03/04/1997				

If basis of payment is other than “A” (Voluntary Payment) or line 37 is equal to “J” or “K”, enter Order # _____

If benefit type is “C” (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent “Other”, please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers’ Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers’ Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	04/01/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 7

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Filing Reason "F" | **Reopening Claim**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-2	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Burn (310)	Arm (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
A	03/06/1995	5	0

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$274.40

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$274.40	02/02/1997	03/12/1997	$1,536.64	1997	A

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	03/13/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 7

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Filing Reason "F" | **Reopening Claim**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 2

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code

13. Employer Street Address	14. City	15. State	16. ZIP Code

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912			

Part B

25. Nature of Injury	26. Part of Body

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
	04/04/1997		

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
F	$274.40

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$274.40	04/05/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	04/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 8

Back to List of Examples

Filing Reason "G" | **Reopening & Closing Claim**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-2	02/03/1997	02/07/1997

Part B

25. Nature of Injury	26. Part of Body
Burn (310)	Arm (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
A	02/01/1997	5	0

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	$274.40

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$274.40	02/02/1997	03/12/1997	$1,536.64	1997	A

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	03/13/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 8

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Filing Reason "G" | **Reopening & Closing Claim**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 2

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/01/1997	DOE, John R.		

6. Employee Street Address	7. City	8. State	9. ZIP Code

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code

13. Employer Street Address	14. City	15. State	16. ZIP Code

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912			

Part B

25. Nature of Injury	26. Part of Body

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
	04/04/1997		

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
G	274.40

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	A		$274.40	04/05/1997	04/20/1997	$548.80	1997	A

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	04/22/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 9

Back to List of Examples

Filing Reason "H" | **Yearly Report of Partial Payments**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	11/04/1997	DOE, John R.	09/04/1950	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	002

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	11/08/1997	11/11/1997

Part B

25. Nature of Injury	26. Part of Body
Burn (310)	Arm (520)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$450.00	$0.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	11/04/1997	6	3

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$299.54

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	B			11/05/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers' Disability Compensation Act, 408.31(6a-d) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	11/14/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

Example 9

Back to List of Examples

Filing Reason "H" | **Yearly Report of Partial Payments**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 2

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	11/04/1997	DOE, John R.		

6. Employee Street Address	7. City	8. State	9. ZIP Code

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code

13. Employer Street Address	14. City	15. State	16. ZIP Code

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912			

Part B

25. Nature of Injury		26. Part of Body	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
H	$299.54

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
A	B			11/05/1997	12/30/1997	$183.14	1997	
A	B			12/31/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.	Authority: Workers' Disability Compensation Act, 408.31(6a-d) Completion: Mandatory Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	01/02/1998

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

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John R. Doe
SS# 111-22-3333
DOI: 11/04/1997

From	Through	Average Weekly Wage (AWW)	80% After-Tax AWW	Weekly Wages Earned (WWE)	80% After-Tax WWE	Partial Rate
11/05/1997	11/11/1997	$450.00	$299.54	$400.00	$269.96	$29.58
11/12/1997	11/18/1997	$450.00	$299.54	$386.00	$261.68	$37.86
11/19/1997	11/25/1997	$450.00	$299.54	$450.00	$299.54	0
11/26/1997	12/02/1997	$450.00	$299.54	$410.00	$275.87	$23.67
12/03/1997	12/09/1997	$450.00	$299.54	$320.00	$222.30	$77.24
12/10/1997	12/16/1997	$450.00	$299.54	$425.00	$284.75	$14.79
12/17/1997	12/23/1997	$450.00	$299.54	$450.00	$299.54	0
12/24/1997	12/30/1997	$450.00	$299.54	$450.00	$299.54	0
					TOTAL	**$183.14**

Example 10

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Filing Reason "B" - Open Award

Benefits ordered at $345.98 per week from 03/12/1995

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
999-88-7777	03/11/1995	DOE, Jane S.	06/15/1942	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	000

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D11111	03/13/1995	05/08/1997

Part B

25. Nature of Injury	26. Part of Body
Heart Attack (991)	Heart (801)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$520.00	$50.00		

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
B	03/11/1995	5	1

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$345.98

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
B	A		$345.98	05/08/1997				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # 042097008

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	05/10/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

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REPORT OF ACCRUED BENEFITS

SS# **111-22-3333** DOI **03/11/1995** Employee Name **DOE, John R.**

Order # **042097008** Basis Payment Code **B** Year Paid **1997**

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
A	**A**	**$345.98**	**03/12/1995**	**05/07/1997**	**$38,957.35**	Deps **1** Base Amt $ **345.98** Adjustment Code ___ $ ______ ___ $ ______
				05/07/1997	**$4,124.46**	Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______
						Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______
						Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______
						Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______
						Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______
						Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______
						Deps ____ Base Amt $ ______ Adjustment Code ___ $ ______ ___ $ ______

Basis of Payment
- A = Voluntary Payment
- B = Open Award
- C = Closed Award
- D = Stipulated Award
- E = Compromise
- F = Form 115 Voluntary Pay

Benefit Type
- A = General Disability
- B = Partial Wage Loss
- C = Specific Loss
- D = Permanent Total
- E = Death
- F = Other

Special Payment
- A = Accrued Benefits
- B = Interest
- C = 30% Appeal Adjustment
- D = Other

Weekly Adjustments to Base Rate
- A = Wage Continuation Offset
- B = Social Security Coordination
- C = Pension Offset
- D = Unemployment Offset
- E = Disability Insurance Offset
- F = Self-Insurance Offset
- G = Other Benefit Coordination
- H = Age 65 Reduction
- I = Compensation Supplement
- J = Advance Payment
- K = 30% Appeal Adjustment
- L = SIF Differential Benefits
- M = Double Compensation
- N = Third-Party Offset
- O = 2-Years Continuous Disability
- P = Recoupment of Overpayment
- Q = Other

Example 11

Back to List of Examples

Basis of Payment "E" - Compromise

(Termination reason not required)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	02/05/1997	DOE, John R.	06/15/1942	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	000

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	02/10/1997	05/02/1997

Part B

25. Nature of Injury	26. Part of Body
Inflamation (260)	Hip (440)

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
D	

37. Weekly Adjustments to Base Rate

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

_____ $ _____ _____ $ _____ _____ $ _____ _____ $ _____

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
E	A					$1,500.00	1997	

If basis of payment is other than “A” (Voluntary Payment) or line 37 is equal to “J” or “K”, enter Order # 042897010

If benefit type is “C” (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent “Other”, please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers’ Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers’ Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	05/12/1997

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.

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Benefit Type "D" **Permanent Total**

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
P O Box 30016, Lansing, MI 48909

Filing# 1

Part A

1. Social Security Number	2. Date of Injury	3. Employee Name (Last, First, MI)	4. Date of Birth (MM/DD/YYYY)	5. Date of Death
111-22-3333	10/15/1995	DOE, John R.	06/15/1942	

6. Employee Street Address	7. City	8. State	9. ZIP Code
123 Elm Street	Lansing	MI	48910

10. Employer Name	11. Federal I.D. Number	12. Injury Location Code
Smith's Auto Repair	38-1111111	000

13. Employer Street Address	14. City	15. State	16. ZIP Code
3310 Baker Street	Lansing	MI	48915

17. Carrier or Self-Insured Name	18. NAIC or Self-Insured Number
United States Ins. Co.	99999999

19. Service Company/TPA Name (If applicable)	20. Service Company/TPA I.D. Number

21. ZIP Code of Issuing Office	22. Carrier or Self-Insured Claim Number	23. Date Carrier Received Notice of Injury	24. Date First Payment Made
48912	D12345-1	10/18/1995	10/21/1995

Part B

25. Nature of Injury	26. Part of Body
Industrial Loss of Use	Legs

27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
$226.00			

31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
D	10/15/1995	5	2

Part C

35. Reason for Filing	36. Weekly Compensation Base Rate
A	$153.80

37. Weekly Adjustments to Base Rate

L	$ 32.67		$		$		$
	$		$		$		$

38. Weekly Amount Being Reimbursed by a Fund (Not reported in line 37)

	$		$		$		$

Part D

Basis of Payment	Benefit Type	Special Payment	Total Weekly Rate	From	Through	Total Amount Paid	Year Paid	Termination Reason
B	D		$186.47	10/16/1995				

If basis of payment is other than "A" (Voluntary Payment) or line 37 is equal to "J" or "K", enter Order # _____

If benefit type is "C" (Specific Loss), enter number of weeks _____ and effective date of loss _____

If any filing codes on this form represent "Other", please be specific _____

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, 408.31(6a-d)
Completion: Mandatory
Penalty: Workers' Disability Compensation Act, 418.631; 418.801

This is to certify that a copy of this form has been mailed or given to the employee

39. Authorized Signature	40. Person Handling Claim (Please Print)	41. Telephone Number	42. Date
	Bill Parker	(517) 999-9999	10/21/1995

NOTICE TO EMPLOYEE: If any of the above information is incorrect, please contact the individual named in line 40.